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Indian Health Service
FY 2003 Performance Plan
FY 2002 Revised Final Performance Plan
and FY 2001 Performance Report

January 31, 2002

Congressional Justification Submission

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Part I - AGENCY CONTEXT FOR PERFORMANCE MEASUREMENT

Tomorrow

We have wept the blood of countless ages as each of us raised high the lance of hate.
Now let us dry our tears and learn the dance and chant of the life cycle.
Tomorrow dances behind the sun in sacred promise of things to come for children not yet born,
for ours is the potential of truly lasting beauty, born of hope and shaped by deed.

Peter Blue Cloud

Overview of the Context of GPRA in the IHS

The Indian Health Service (IHS) has embraced the Government Performance and Results Act (GPRA) and its requirements as an extension of the public health approach that we have used for almost a half of a century. In this document the initial FY 2003 and revised final FY 2002 Performance Plans have been merged with the FY 2001 Performance Report consistent with the required format developed within the Department of Health and Human Services (HHS). This plan is submitted as our best effort in response to the proposed *Healthy People 2010* goal of achieving equivalent and improved health status for all Americans over the next decade. It presents a strategic set of performance indicators to address the significant health problems the American Indian and Alaska Native (AI/AN) population experience.

Indeed the disparity in health status that the IHS must address is formidable, particularly in terms of death rates. Comparing the 1996-1998 Indian (IHS service area) age-adjusted death rates with the U.S. all races population in 1997 reveals greater death rates in the AI/AN population for:

1) alcoholism - 638% greater,
2) tuberculosis - 400% greater,
3) diabetes mellitus - 291% greater,
4) unintentional injuries - 163% greater,
5) suicide - 91% greater,
6) pneumonia and influenza - 67% greater,
7) homicide - 81 % greater,
8) gastrointestinal disease- 38% greater,
9) infant mortality - 24% greater, and
10) heart disease, 20% greater.

It was not surprising that a Harvard School of Public Health/Centers for Disease Control and Prevention (CDC) study found that the lowest life expectancies in the country (including inner city ghettos) for both men and women exists in Indian communities. These rates are similar to ones seen in sub-Saharan Africa and are the lowest of any nation in this hemisphere except Haiti. It is also not surprising that these Indian people have also been identified as living in the poorest counties in the country. Even more alarming, the most recent data (provided in Section 1.2 of this plan) documents that the mortality disparities for AI/AN people are actually worsening.

Despite these formidable challenges, the IHS in partnership with its stakeholders, view the GPRA as part of the process for assuring the capacity to serve AI/AN people. We are optimistic about the future and encouraged with the improved level and quality of consultation that is occurring between tribes and components of the Department. We are also encouraged with growing awareness and support from an expanding network of agencies and organizations also

interested in improving the health of the AI/AN people. The growth of these partnerships and coalitions will be critical to our long-term success.

The performance indicators in this plan are predominately directed at assuring access to essential health services for AI/AN people. The growing AI/AN population with increasing disease rates have significantly raised demand for urgent care and limited our ability to consistently increase access to preventive and health maintenance services. Improved health outcomes are likely to take a generation before they are realized. Our most pressing challenge is decreasing the escalation of disease mortality and morbidity evident from the most recent data presented in Section 1.2 of this document.

This plan and its predecessors represent significant efforts over the past four years by the IHS and its diverse stakeholders in which a " bottom-up" approach to budget formulation and GPRA performance planning has been used. This approach was adopted to support the Indian self-determination process and honor the "government to government" relationship that exists with tribes. Beginning with the development of the FY 1999 budget and Performance Plan, regional meetings were held to outline the GPRA and budget formulation process for all IHS Area Formulation Teams.

These Area teams then provided representatives of their local programs the opportunity for input and review of the Area recommendations, which were then compiled. For the past three years Area Formulation Team representatives then came together along with tribal leaders and representatives from several Indian organizations to merge and reconcile the Area recommendations into a single IHS set of budget priorities.

Using these identified budget priorities, a multidisciplinary team of stakeholders that included health program, budget, and information technology experts, epidemiologists, and IHS and tribal managers developed this plan. In addition to the identified budget priorities this plan reflects the context of the Department of Health and Human Services (HHS) Strategic Plan, the Secretary's Budget Priorities for FY 2003, and the *Healthy People 2010* goals and objectives.

This performance plan represent the most cost-effective public health approach to best address the health needs for AI/AN people with the proposed budget. By most objective measures of efficiency and effectiveness in addressing health problems, we have been and are frugal and have a proud history of accomplishments that document the achievement of significant results long before it was required by law. Over the next decade, in partnership with our stakeholders, we intend to accomplish even more.

1.1 Agency Mission and Long-Term Goals

The Indian Health Service (IHS) has the responsibility for the delivery of health services to Federally-recognized American Indians and Alaska Natives (AI/AN) through a system of IHS, tribal, and urban (I/T/U) operated facilities and programs based on treaties, judicial determinations, and Acts of Congress. In 1995 a group of stakeholders charged by the IHS Director to reorganize the IHS, revised the mission and goal and added a foundation as follows:

MISSION:
The mission of the Indian Health Service, in partnership with American Indian and Alaska Native people, is to raise their physical, mental, social, and spiritual health to the highest level.

GOAL:
To assure that comprehensive, culturally acceptable personal and public health services are available and accessible to American Indian and Alaska Native people.

FOUNDATION:
To uphold the Federal Government's obligation to promote healthy American Indian and Alaska Native people, communities, and cultures and to honor and protect the inherent sovereign rights of Tribes.

These three responsibilities have been integrated into the evolving IHS component of the Department of Health and Human Services (HHS) Strategic Plan for the GPRA to yield four broad IHS Strategic Objectives to guide the Agency into the next millennium. The first is essentially a restatement of the HHS Strategic Plan Objective 3.6 *Improve the health status of American Indian and Alaska Natives*, while the remaining three strategic objectives represent the means to achieve the first:

Strategic Objective 1: Improve Health Status

To reduce mortality and morbidity rates and enhance the quality of life for the eligible American Indian and Alaska Native population.

Strategic Objective 2: Provide Health Services

To assure access to high quality comprehensive public health services (i.e., clinical, preventive, community-based, educational, etc.) provided by qualified and culturally sensitive health professionals with adequate support infrastructure (i.e., facilities, support staff, equipment, supplies, training, etc.)

Strategic Objective 3: Assure Partnerships and Consultation with I/T/Us

To assure that I/T/Us, and IHS Area Offices and Headquarters achieve a mutually acceptable partnership in addressing health problems:

- ***providing adequate opportunities for I/T/Us and American Indian and Alaska Native organizations to participate in critical functions such as policy development and budget formulation, and***
- ***assuring that I/T/Us have adequate information to make informed decisions regarding options for receiving health services.***

Strategic Objective 4: Perform Core Functions and Advocacy

Consistent with the IHS Mission, Goal and Foundation, to effectively and efficiently:

- ***execute the core public health and inherent Federal functions*, and**
- ***advocate for the health care needs of the American Indian and Alaska Native people.***

These Strategic Objectives are essential for the realization of our Mission, Goal, and Foundation over the next five to 10 years by setting the programmatic, policy, and management course for the IHS. They are also consistent with the most recognized approach to evaluating health care organizations in that they address the *structure, process,* and *outcomes* of health care delivery and provide the conceptual and philosophical framework for the performance indicators outlined in this annual performance plan.

During FY 2001, a diverse group of IHS stakeholders were charged by IHS leadership with the development of an IHS specific strategic plan for the realization of the IHS Mission, Goal, and Foundation over the current decade. This Strategic Planning Workgroup brought together expertise in clinical care, public health, epidemiology, health care administration, health care financing, community development, tribal sovereignty, legislations, education, environmental health, facilities construction, with representation from:

- IHS local, Area Office, and Headquarters staff
- Tribal health leadership
- Urban Indian health leadership
- HHS, Office of the Secretary
- The Self –Governance Advisory Council
- The National Indian Health Board
- The Friends of Indian Health Service

The development of this plan began with a systematic assessment of the strengths, weaknesses, threats, opportunities, health trends, statutory and regulatory issues, and current and projected funding of the Indian health care system. During this process the workgroup collectively came to the realization that the long-term success of the IHS was largely dependent on effective collaboration and synergism between the IHS and its diverse stakeholders. In essence, the realization of the Mission, Goal and Foundation is not achievable without this focus.

As now developed, the plan is composed of four sections and an appendix. Each of these sections addresses a strategic goal and include:

1. Build Healthy Communities
2. Achieve Parity in Access by 2010
3. Provide Compassionate Quality Health Care
4. Embrace Innovation

For each section in the plan, the strategic goal is broken down further into several specific objectives that include a discussion of ***Purpose and Outcome***, ***Strategy and Processes***, and a list of proposed ***Performance Measures*** to assess progress in reaching each objective. The initial draft of this plan will be provided to the Indian Health Leadership Council in the first quarter of calendar year 2002. Examples of proposed long-term performance measures from the plan are:

- mortality rates for the AI/AN population
- Years of Potential Life Lost

- diabetes prevalence rates
- immunization rates for children and adults
- Quality of Life Index
- cancer survival rate
- obesity prevalence rate
- rate of children free of dental decay and adults with 20 or more functional teeth
- prevalence of substance abuse (i.e., alcohol, drugs, and tobacco)
- percent of homes with adequate water and sewage facilities
- percent of I/T/Us with access to public health infrastructure meeting defined standards
- percent of I/T/Us with automated health data systems meeting defined standards
- constant dollar per capita funding available for eligible AI/AN health care
- retention rates of health care providers within I/T/U system
- percent of IHS Area and Headquarters staff meeting recommended job qualifications
- medical error rates
- consumer satisfaction rates
- percentage of I/T/Us with internet access for patients and providers
- Human Resource Management Index annual score for IHS

Data for most of these measures are already available and developing strategies for securing data for selected measures not currently available will be a major part of this effort. The ultimate challenge will be to make significant improvements in these diverse measures. This is particularly true for those that address health status because they represent many of the areas of greatest disparities between the AI/AN people and the U.S. general population. Eliminating even a few of these disparities within this decade would represent a public health accomplishment of unparalleled magnitude in recent history.

1.2 Organization, Programs, Operations, Strategies and Resources

Humankind has not woven the web of life. We are but one thread within it. Whatever we do to the web, we do to ourselves. All things are bound together. All things connect

Chief Seattle

The IHS is the Operating Division (OPDIV) within HHS charged with administering the principal health program for the eligible AI/AN population. The IHS provides comprehensive health services through its I/T/U system of facilities and programs. Many of the people served by the IHS live in some of the most remote and poverty stricken areas of the country, and these health services represent their only source of health care. In terms of magnitude, the I/T/Us provide health services to over 1.4 million people through 153 service units composed of 568 health care delivery facilities, including 49 hospitals, 219 health centers, 7 school health centers, and 293 health stations, satellite clinics, and Alaska village clinics.

Within this system, Indian tribes deliver IHS-funded services to their own communities with about 44 percent of the IHS budget in 13 hospitals, 161 health centers, 3 school health centers, and 249 health stations, satellite clinics, and Alaska village clinics. Tribes who have elected to retain the Federal administration of their health services at the present time receive services with about 37 percent of the IHS direct services budget in 36 hospitals, 58 health centers, 4 school health centers, and 44 health stations and satellite clinics. The range of services includes inpatient and ambulatory care, extensive preventive care, and a diversity of health promotion and disease prevention activities.

In addition, various health care and referral services are provided to Indian people away from the reservation settings through 34 urban Indian health programs. It is estimated that almost 60 percent of all AI/ANs now reside in or near urban centers and available evidence suggests they have considerable health care needs. The Contract Health Services program is an integral part of the IHS system for purchasing services from non-IHS providers to support, or in some cases to provide in lieu of, direct care services. In FY 2003, Contract Health Services is anticipated to represent about 16 percent of the IHS Budget and is distributed to IHS and Tribal programs at the same relative percentage as direct services funding (i.e., IHS = 37%, Tribal = 63%). In FY 2000, the IHS Fiscal Intermediary processed approximately 350,000 payment claims.

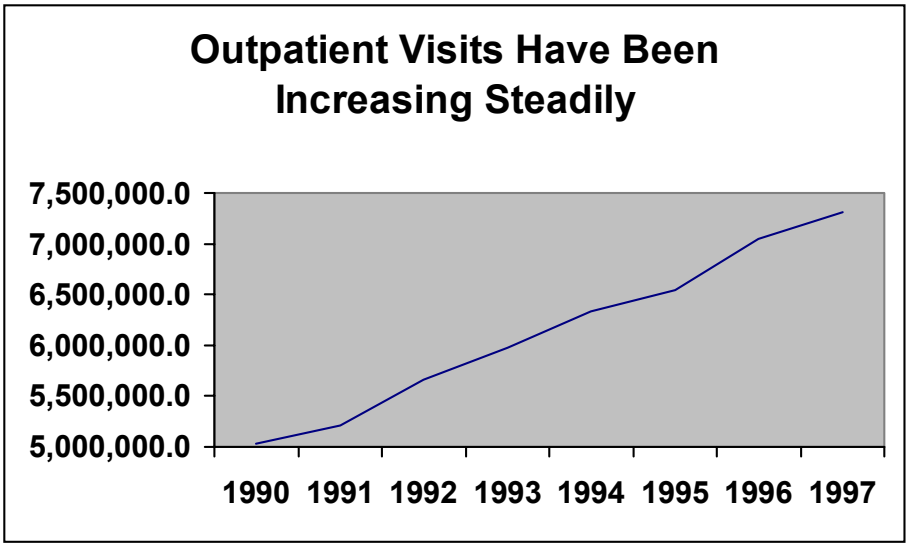
Since its inception in 1955, the IHS has demonstrated the ability to effectively utilize available resources to improve the health status of the AI/AN people. This contention is supported by dramatic improvements in mortality rates between 1972-74 and 1994-96, including:

- maternal mortality reduced 78% (27.7 to 6.1 per 100,000)
- tuberculosis mortality reduced 82% (10.5 to 1.9 per 100,000)
- gastrointestinal disease mortality reduced 76% (6.2 to 1.5 per 100,000)
- infant mortality reduced 66% (22.2 to 7.6 per 100,000)
- accident mortality reduced 57% (188.0 to 80.6 per 100,000)
- pneumonia and influenza mortality reduced 50% (40.8 to 20.2 per 100,000)

When compared with the U.S. general population, the IHS achieved these improved outcomes in the face of several complicating factors including:

- lower per capita expenditures for health care
- limited availability of providers (e.g., half the physicians and nurses per capita)
- higher costs for providing health care in isolated rural settings (loss of economies of scale)
- lack of facilities in numerous locations and many outdated existing facilities (i.e., average age of IHS facilities is 32 years in comparison to 9 years for the private sector)
- lower utilization of health care services (e.g., 25% annual utilization of dental service for AI/ANs compared to about 60% for US population overall)
- significantly higher health care needs because of poor health status (significantly higher rates of diabetes, alcoholism, injuries, oral diseases, and overall death rate)
- high unemployment, poverty, substandard housing, and other recognized contributing factors to reduced health status

And with the AI/AN population growing of over two percent annually couple with high disease rates overall outpatient visits have steadily increased as evident in the following chart:



This health care demand has resulted in significant decreases in access to non-urgent primary services that include:

- 37% decline in the number of well child services between FY 1992-97
- 35% decline in the number of physical exams between FY 1994-97
- 26% reduction in the proportion of people receiving dental services between FY 1992-99
- 68% reduction in water systems fluoridated between FY 1991-99

- 178% increase in denials of claims from health care contractors between FY 1994-00

The net result of this trend of increasing demand for urgent care has reduced the capacity for the IHS to provide the primary services that are critical to long-term health maintenance and improvement. Of greatest concern is the continued trend of increasing AI/AN mortality. The most recent fully analyzed mortality data (FY 1998) available from the National Center for Health Statistics adjusted for miscoding of AI/ANs document an upward trend in deaths of AI/AN people for the period of 1997-99 compared to the period 1994-96 from cancer, diabetes, suicide, motor vehicle accidents, and heart disease (see Chart I on the following page).

The net result of these categorical increases is an overall increase in death rate for AI/AN people from 699 per 100,000 population for the period 1994-96 to 715 per 100,000 population for the period 1996-98. In addition, preliminary data has just become available for FY 1999 and shows that the 1997-1999 age-adjusted mortality rate increased approximately 4 percent from the 1994-1996 rate. Analyses of the contributing causes of this latest increase in mortality will soon be available but for now it is clear that AI/AN health disparities are growing.

Given these trends and challenges, the IHS and its diverse stakeholders have been reorganizing the IHS and are continually developing alternative methods to assure more efficient health programs and administrative support to Indian communities. The redesign efforts emphasize patient care; strengthening government to government relations; streamlining administration and management; quality support services to field-based health care activities; diversification of operations; staffing new facilities; and fair treatment of employees. This performance plan supports and provides quantifiable measures for each of these priorities.

Chart I
MORTALITY RATE DISPARITIES CONTINUE

American Indians and Alaska Natives in the IHS Service Area
1994-96 to 1996-98 and U.S. All Races 1995 and 1997
(Age-adjusted mortality rates per 100,000 population)

	AI/AN Rate 1996-98	U.S. All Races Rate 1997	Ratio: AI/AN to U.S. All Races	AI/AN Rate 1994-96	U.S. All Races Rates 1995	Ratio: AI/AN to U.S All Races
ALL CAUSES	**715.2**	**479.1**	**1.5**	**699.3**	**503.9**	**1.4**
Alcoholism	**46.5**	**6.3**	**7.4**	**48.7**	**6.7**	**7.3**
Tuberculosis	**1.5**	**0.3**	**5.0**	**1.9**	**0.3**	**6.3**
Diabetes	**52.8**	**13.5**	**3.9**	**46.4**	**13.3**	**3.5**
Motor Vehicle Crashes	**54.8**	**15.9**	**3.4**	**54.0**	**16.3**	**3.3**
Suicide	**20.2**	**10.6**	**1.9**	**19.3**	**11.2**	**1.7**
Homicide	**14.5**	**8.0**	**1.8**	**15.3**	**9.4**	**1.6**
Cervical Cancer	**4.2**	**2.5**	**1.7**	**3.3**	**2.5**	**1.3**
Infant Deaths [1/]	**8.9**	**7.2**	**1.2**	**9.3**	**7.6**	**1.2**
Diseases of the Heart	**157.1**	**130.5**	**1.2**	**156.0**	**138.3**	**1.1**
Cerebrovascular Diseases	**29.5**	**25.9**	**1.1**	**30.5**	**26.7**	**1.1**
Malignant Neoplasms (All)	**124.0**	**125.6**	**1.0**	**116.6**	**129.9**	**0.9**
HIV Infection	**3.3**	**5.8**	**0.6**	**6.2**	**15.6**	**0.4**

[1/] **Infant deaths per 1,000 live births.**

NOTE: American Indian and Alaska Native rates were adjusted to compensate for race misreporting on State death certificates.

The budget supporting this performance plan provides linkage to a crosscutting multidisciplinary approach that addresses complex health problems associated with chronic diseases and harmful behavioral health practices. This approach includes enhancing the integration of our diverse expertise from medical, behavioral health, and community health staff in order to address the top health problems identified by the I/T/Us. Integration of prevention strategies throughout the clinical service activities strengthens the community-based public health model. Furthermore, it is essential to maintain community health programs and supporting partnerships with community resources such as public safety programs, schools, and other community based organizations.

The first priority in the budget request is to continue access to basic health services for AI/AN people. However, achieving this goal may not be enough to halt the decreasing health status of AI/AN people. In this context, the request addresses the multiple health issues affecting the AI/AN population in an attempt to at least slow the downward trend in their health status. But access to essential services must remain at the core of this effort.

The support for public health infrastructure is also fundamental to these activities. These investments will strive to maintain surveillance, prevention and treatment services and are based on “best practices” defined in the public health literature. This approach is consistent with the trend of Federal entities adopting such industry standards. Many of the IHS performance indicators for "treatment" and "prevention" represent our commitment to this process.

An essential component of supporting access to services is to assure that there are adequate facilities and equipment for the provision of health services. The IHS must assure an efficient, safe, and pleasant environment for the provision of services by ongoing maintenance, repair, renovation, and replacement of health care facilities. The funding request for these functions is underpinned by performance measures in the section addressing Capital Programming/ Infrastructure.

Also critical is the provision of contract support costs to the tribal health delivery system. These requested funds will provide for tribal communities to assure that there are utilities, training, clerical staff, administrative and financial services needed to operate health programs. This investment is consistent with the Administration’s commitment to supporting tribal participation in the management of the programs and the principles of the Indian Self-Determination Act.

Finally, water and sewer systems for new and existing homes to maintain progress in preventing infectious diseases and improving the quality of life are addressed in this plan. A specific performance measure is included as part of the Capital Programming/Infrastructure section of this document.

In summary this performance plan and budget request represent a commitment to utilize available resources to the maximum benefit in achieving our mission of improved health status for the AI/AN people.

1.3 Partnerships and Coordination

Given the magnitude of AI/AN health disparities and the resource demands they create, it is critical that the IHS identify and collaborate with all available outside organizations with the capacity, capability, and interest to assist in addressing these diverse health problems. Our resolve to develop this crosscutting network is evident by the number and diversity of collaborative activities that are currently in place and described in this section.

The Indian Health Service has continued to develop and expand its crosscutting collaborations and partnership with other agencies and organizations to achieve common goals and objectives addressing health disparities of American Indians and Alaska Natives (AI/AN). These partnership and collaborations are building capacity across institutions, enhancing program outreach through shared resources, opening dialogue with new partners, developing or disseminating new health care and/or surveillance technologies, securing a variety of training and technical assistance support for I/T/U providers, networking to maximize knowledge and resources, disseminating information through activities of mutual concern, and developing tribally specific community-based, community driven research.

The following examples of recent and developing collaborative activities met one or more of the following criteria:

- clearly presents the true influence that the Federal agency and its programs wield
- shows program coordination as key elements of interest with GPRA implementation to achieve performance goals
- clarifies roles of the agency, related Federal agencies, and performance partners
- demonstrates agency strategy to coordinate efforts of crosscutting programs-activities
- documents uniqueness of the agency and its distinguishable contributions
- presents agency plans for eliminating duplication and overlap

PROGRAM COORDINATION BY PARTNERS WITHIN DHHS:

Administration for Children and Families/Head Start Bureau

- The IHS has had a longstanding collaboration (15+ years) with the Administration for Children and Families (ACF) Head Start Bureau. The intra-agency agreement between the IHS and the Head Start Bureau is for IHS to provide training and technical assistance to 177 Head Start grantees, which are part of the American Indian Program Branch of the ACF, in the area of health and safety, nutrition, dental, behavioral health and general medical services. The collaboration also provides for a full-time health and safety specialist position and a computerized data system for the IHS Head Start program.

- The Head Start Bureau, ACF is collaborating with the IHS Diabetes Program, Nutrition program and the clinical providers to monitor and develop programs to address the 0-5 age group of AI/AN in prevention. This is an intervention program to address rising trends in obesity in this age group.

Agency for Healthcare Research and Quality

- The IHS and AHRQ co-sponsored a conference entitled "Crafting the Future of American Indian and Alaska Native Health into the Next Millennium." The purpose was to promote health care partnerships, including research partnerships, between academic medical centers and AI/AN organizations and tribes. IHS and AHRQ are maintaining collaborative efforts; strengthening health services research; increasing opportunities for the Native American population into research; and strengthening the research infrastructure of AI/AN organizations.

- The AHRQ Office of Research Review, Education and Policy (ORREP) is collaborating on potential research training for AI/AN people. The ORREP also participated in the Annual IHS Research Conference. Discussions regarding additional research possibilities have been held with other AHRQ staff.

- The AHRQ Center for Practice and Technology Assessment and the IHS have had discussions regarding possible collaboration and services through their evidence-based practice centers, including technology assessment and other related research activities.

- A collaboration with AHRQ is being pursued to support an Indian Primary-Care Based Research Network

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- A collaboration with AHRQ is being pursued to support evaluation of medication errors in the Indian health system

- A collaboration with AHRQ is being discussed for development in 2002 to field an update of the Survey of American Indian and Alaska Natives (SAIAN) as part of the Medical Expenditures Planning Survey (MEPS).

- The collaboration continues on the development of the Healthcare Utilization Project to incorporate IHS data into a large nationwide inpatient database that AHRQ manages with the States.

Centers for Disease Control and Prevention Umbrella Agreement

The IHS and CDC have extensively collaborated in addressing a diversity of health issues over the past decade. As a result, the IHS and CDC now annually develop an umbrella work plan that includes specific agreements with the following CDC entities:

- **CDC/Agency for Toxic Substances and Disease Registry Tribal Liaison:** The purpose of this position is to strengthen inter-government response to tribal public health needs through

consultation, networking, strategic planning, and improved coordination among federal and state governments, tribal communities, urban Indian health programs, and academic institutions. This helps to ensure that Indian health interests are represented in program decisions and policies.

- **Epidemiology/Preventive Medicine Training:** The IHS National Epidemiology Program hosts CDC Epidemic Intelligence Service (EIS) Officers for their two-year field epidemiology training experience, and Preventive Medicine Residents (PMRs) for a one-year field training. IHS can provide similar assignments for Prevention Specialists (Public Health Prevention Service). It provides the trainees practical experience while providing a service to the IHS. The IHS Epidemiology and the CDC/EPO are currently collaborating on a project to make basic epidemiology training available to tribal health departments; Navajo Nation is the pilot site.

- **CDC/National Center for Chronic Disease Prevention and Health Promotion-Chronic Disease Annual Workplan:** This intra-agency agreement/workplan was developed in 1990 consisting of two distinct segments, the R-90 (services provided by IHS to CDC) and the M-90 (services provided by CDC to IHS). Both segments consist of an array of components, the specifics of which are negotiated on an annual basis in the form of a workplan. In many cases IHS provides the FTE and CDC provides salaries for some of the staff supporting these activities. Highlights of this plan follows:

    - **Division of Cancer Prevention and Control (DCPC):** Provides for a field assignment for a CDC Public Health Advisor (PHA) to provide technical assistance/guidance for capacity building with state health departments, IHS tribes and tribal organizations. DCPC also provides funds for colposcopy training and other IHS cancer control activities. IHS provides an additional three FTE's to CDC, located in Atlanta, for direct technical assistance and consultation to tribes and tribal organizations through the National Breast and Cervical Cancer Early Detection Program, which currently funds 14 tribal screening programs.

    - **Division of Adult and Community Health (DACH):** IHS provides DACH with four FTE's located in Atlanta to support research, technical assistance, training, and planning. DACH will be the lead in overall planning, coordinating, and monitoring of chronic disease-related activities. The principal activities include but are not limited to:

        - **Memorandum of Understanding - IHS CDC/University of New Mexico:** The IHS provides an FTE for a field assignee with a Doctorate in epidemiology or related field to serve as a Senior Research Scientist for University of New Mexico Prevention Research Center for activities related to AI/AN communities.

    - **Health Promotion Activities for Older Adults:** This component provides technical assistance in the design, implementation and analysis of surveys for health promotion

activities for older adults. Information from these surveys will be used to direct program development and evaluation of the health needs of AI/AN aged 55 and older.

- **Behavioral Surveillance Branch (BSB):** Using the CDC Behavioral Risk Factor Surveillance Survey (BRFSS) this collaboration responds to requests from tribal epidemiology centers (Alaska Native EPI Center, Inter-Tribal Council of Arizona; Northwest Tribal Research Center, and Great Lakes Inter-Tribal Council) to assist in creating and/or analyzing BRFSS data files.

- **Cardiovascular Health:** The DACH provides technical assistance in the design, implementation, and evaluation of cardiovascular risk factor prevention and intervention programs. Provides dissemination of lessons learned from the Inter-Tribal Health Project (ITHP) to tribal communities in the Bemidji service area of IHS and throughout the United States.

- **Division of Oral Health:** This agreement includes a component to develop, implement and promote water fluoridation in AI/AN communities for dental disease prevention. A field assignee will be placed in Albuquerque with the IHS Environmental Management Branch.

- **Division of Diabetes Translation (DDT):** The IHS provides one FTE located in Atlanta, to support CDC/DDT in providing technical consultation and assistance on public health surveillance of diabetes to define the burden of diabetes and diabetes-related complications among the Native population. The DDT calculates age-specific and age-adjusted prevalence by area; hospitalizations and amputations. The CDC/DDT also provides a field assignee to IHS diabetes Program in Albuquerque to provide consultation and technical assistance in diabetes epidemiology to IHS.

- **Gallup National Diabetes Prevention Center:** The IHS provides five FTEs and funding to NCCDPHP to support the National Diabetes Prevention Center in Gallup, New Mexico. The IHS and the NCCDPHP will jointly provide national leadership to plan, develop, implement and evaluate the National Diabetes Prevention Center under the broad guidance of the Departments of Labor, health and Human Services, Education, and Related Agencies Congressional Appropriations act, H.R. 2264, 1998 Conference Report, page S-12088.

- **Office on Smoking and Health (OSH):** The IHS provides CDC/OSH with one FTE for a field assignee located in Albuquerque, New Mexico, to develop, establish, and maintain a community based program for the prevention and control of tobacco use, and related health problems among AI/AN populations.

- **Division of Reproductive Health (DRH):** The IHS provides three FTEs to DRH to support a multifaceted approach to addressing reproductive-related health problems in AI/AN, including Sudden Infant Death Syndrome, and to assist tribes in community health surveys. One method is collection and analysis of reproductive health and Behavioral Risk Factor Surveillance (BRFS) information. After data collection, DRH

assists tribes and organizations in the analysis, interpretation and dissemination of survey data. The Pregnancy Risk Assessment Monitoring System (PRAMS) conducts State-specific, population-based surveillance of women's behaviors before, during pregnancy and during the child's early infancy. Two FTE's are located in Atlanta and one FTE provides for a field assignee located in Albuquerque, New Mexico.

- **National Center for HIV, STD and TB Prevention (NCHSTP)**

  - **Division of Sexually Transmitted Disease Prevention:** The IHS provides an FTE for the field assignment of a Public Health Advisor (PHA) to assist in the planning, development and implementation of sexually transmitted disease control programs among AI/AN. The PHA is located in Albuquerque, New Mexico.

    - Communicable/Sexually transmitted Disease Prevention and Control: The IHS provides one-half time services of an Epidemiologist to share administratively the activities under this agreement. The agreement provides for the prevention and control of communicable and other sexually transmitted diseases among AI/AN. High rates of Chlamydia trachomatis may be found throughout AI/AN populations. Activities will include: developing and implementing surveillance systems for monitoring trends; initiating and managing national evaluation, screening and intervention programs and identifying high risk populations for other sexually transmitted disease including HIV.

  - **Division of HIV/AIDS Prevention:**
    - Under another collaborative agreement that has been completed an epidemiologist will be designated to assist in the coordination of national surveillance, prevention, and control activities for HIV/AIDS and related opportunistic infections, STDs, and hepatitis B and C among AI/AN people.

    - Further collaboration with CDC/Division of Adolescent and School Health (DASH) is being conducted to provide HIV prevention program activities for the implementation and evaluation of HIV prevention education for AI/AN children and youth in schools on reservations, rural areas, and urban metropolitan areas. Training will be provided to teachers in States that have a significant number of Indian students in the use of a curriculum, "Circle of Life HIV/AIDS Curriculum", developed by IHS. The curriculum is for grades K through 6^{th}.

- **National Center for Infectious Diseases (NCID)**

  - Division of Viral and Rickettsial Diseases, Hepatitis Branch: The IHS provides an FTE for a field assignment to be located in Albuquerque, New Mexico, of an epidemiologist to assist in the planning development, and implementation of hepatitis prevention and control programs among AI/ANs. The purpose of this agreement is to provide for collaborative activities related to prevention and control of hepatitis A and

C in AI/AN communities. The ultimate goal is to reduce the incidence of hepatitis as a health problem in AI/AN populations.

- Special Pathogens Branch: The IHS and CDC have an ongoing intra-agency agreement that targets the hantavirus disease. The purpose of this agreement is to assist in the planning, development and implementation of hantavirus prevention and control programs among AI/ANs. Support provided includes assistance in determining trends in hantavirus morbidity and mortality; identifying and responding to outbreaks; and collaborating with tribal, state and local health departments and community-based organizations.

- **National Center for Injury Prevention and Control (NCIPC):** The NCIPC has had an intra-agency agreement with IHS since 1985 to help reduce unintentional and intentional injuries among AI/ANs. The CDC has assisted IHS with pilot injury surveillance projects, publishing MMWR reports and Surveillance Summaries, teaching in the IHS Injury Prevention training program to build tribal capacity, evaluating community-based injury prevention and control programs, participate in the IHS's national advisory board on injuries, and collaborate as a national partner to raise awareness of injuries as a leading public health problem among AI/ANs. The CDC and the IHS also collaborated with the American Academy of Pediatrics and several tribal groups to present the first ever briefing on injury issues to select Senate staff. The IHS provides an FTE for an Atlanta-based Injury Prevention Specialist who collaborates with IHS on these and other projects.

- **National Immunization Program (NIP)**

  - Vaccine-Preventable Disease Control: The IHS provides an FTE for the field assignment of a Public Health Advisor to assist in the planning, development and implementation of vaccine-preventable disease control programs among AI/ANs. The PHA, located in Albuquerque, New Mexico, will assist in implementation of the Vaccines for Children (VFC) program among AI/AN children.

OTHER IHS/CDC COOPERATIVE AGREEMENTS : The IHS and CDC collaborate on various specific projects in partnership with tribes, tribal coalitions, Alaska Native corporations, and academic institutions who are recipients of CDC and/or IHS cooperative agreement funds. Such activities may or may not occur in direct relationship to the aforementioned formal Intra-agency Agreements.

Food and Drug Administration

- The IHS and the FDA collaborated on recommendations to reduce patient and occupational exposures; to promote principles of radiation protection, and to allow the FDA to monitor radiation protection for conformance with existing agency and Federal policies.

- The IHS has a collaborative agreement with the FDA Center for Devices and Radiological Health for mutual support in the evaluation and use of medical radiologic equipment. During the past year the FDA provided equipment and training to allow IHS institutional

environmental health staff to conduct performances and quality assurance evaluations of 300 medical and 1,000 dental diagnostic x-ray units.

Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration)

The collaboration with the Centers for Medicare and Medicaid Services (CMS) covers an array of issues that critically impact operational issues related to the Indian health care system and the provision of services by the IHS to its stakeholders. Many of the issues were directed at increasing the understanding of federal and state government agencies about the government-to-government relationship with the 550 federally recognized tribes and the need for consultation with tribal governments on actions that affected them. Following are current and ongoing collaboration issues.

- The IHS and CMS Joint Indian Health Steering Committee continues to be an effective tool creating a better understanding of the unique needs of the IHS and, Tribes (I/T) for appropriate, representative policies.

    - Legislation Subcommittee: The IHS will continue to work with CMS on legislative issues, e.g., reauthorization of the Indian Health Care Improvement Act, using Medicare rates for CHS payments, expanding payments to outpatient ambulatory clinics and for physician services.
    - Operations Subcommittee: The IHS will continue to work with CMS on program policy and operation issues such as reimbursement policies, outreach and education, and data sharing and other policy guidance.
    - Cost Reports Subcommittee: The IHS in collaboration with CMS will address short and long range plans for development of hospital cost reports. This includes short and long range plans for a cost accounting system, and training of IHS finance and management staff.

- The IHS and CMS continue their collaboration with the National Medical Education program (NMEP) Task Force. The NMEP ensure that beneficiaries receive accurate, reliable information about their benefits, rights and health plan options; have the ability to access information needed to make informed choices; and perceive the NMEP (the Federal government and our private sector partners) as trusted and credible sources of information. The NMEP activities have included publishing Medicare & You Handbook, Internet activities, Toll-Free Medicare choices Helpline, National Alliance Network, Enhanced Beneficiary Counseling from State Health Insurance Assistance programs, the National Train-the-Trainer Program, and Regional Education About Choices in Health Campaigns.

- The IHS and CMS formed the Home Health Care workgroup to develop draft regulations to implement the Prospective Payment System. The workgroup will be reviewing amendments to the current regulations.

- The IHS and CMS work closely on the HHS Value-Based Purchasing Work Group that is part of the Quality Interagency Coordination Council. They have pursued the national goal

to reduce the number of medical errors in health care environments and to build a safer health system nationally.

- An IHS Liaison has been appointed to advise CMS managers on policy information respective to health care programs administered by the I/T/U continues to be beneficial and effective.

- The IHS and CMS collaborated on the Prospective Payment System Minimum Data Sets that include current cost reports. These files are used to calculate hospitals' current Diagnostic Related Group prospective payment rates, etc., and will provide IHS with the necessary information to make payments in a timely manner.

- The IHS and CMS collaboration resulted in new Medicare and Medicaid reimbursement rates for the IHS and IHS-funded tribal facilities. This revenue source is used for medical staff, improved training, the purchase of additional medical equipment and improved facilities for IHS.

- The IHS and CMS collaborated on legislative issues that resulted in important CMS policies and enhanced operational issues, i.e. Medicaid program waivers, the Children's Health Insurance Program (CHIP), new policy guidance and proposed regulations exempting AI/AN from any cost sharing provisions under CHIP for eligible children.

- The IHS and CMS collaborated on Medicare enrollment data to provide more accurate information for assessing outreach to Medicare beneficiaries that are AI/AN to establish an accurate database for IHS. This information will be used also for analyzing AI/AN Medicare utilization patters. Also, this database will be used by the IHS in claims processing to reduce the number of IHS Medicare claims rejected by CMS fiscal intermediaries for errors.

- The IHS/CMS collaborated together to discuss major issues affecting the policies and operations of each agency such as interfacing with State health care reform activities, Federal waiver demonstrations, advising CMS HQs and Regional Officers, State Medicaid Directors on how to consult with tribes in their States when drafting Medicaid waiver proposals.

Health Resources and Services Administration

- The IHS continues to provide support for the PHS Primary Care Policy Fellowship program to bring 30 Federal and private sector primary care leaders together to enhance their capabilities to advance the primary care agenda at the local, State, and national level. It also sponsors a mid-year Primary Care Networking Conference for collaborations.

- The IHS and HRSA have recently completed an agreement to provide HIV/AIDS education and training to health care providers that provide health care services to AI/AN people.

- The IHS and Federal Occupational Health Program (FOHP) collaborated to share software enabling IHS to receive occupational health, environmental assessment and health

information management support services from various resources and enables the IHS to meet its environmental management responsibilities.

National Institutes of Health

- The IHS and the National Institute of General Medical Sciences (NIGMS) are collaborating on bringing together in partnership academic research institutions, Indian tribes or Indian community based organizations. The purpose is to strengthen capacity for research on diseases of importance to American Indians and to develop a cadre of American Indian scientists and health professionals who will become active participants in competitive NIH funded research.

- The IHS and the National Institute for Dental and Craniofacial Research, in partnership with the State University of New York at Buffalo have a longstanding (five year) partnership to develop treatment regimens for individuals with diabetes who also suffer from periodontal disease. The first site for the study was Sacaton, Arizona, and the current site is Santa Fe, New Mexico. The results have been reported in the professional literature and the technology is being exported under a grant program.

- The IHS and National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) collaborate on facilities and services to conduct clinical research studies primarily in the areas of diabetes and digestive diseases at the Phoenix Indian Medical Center (PIMC), Arizona. It also facilitates collaborative research interest in diabetic renal disease and epidemiologic surveys and studies.

HHS Office of Women's Health

- The National Indian Women's Health Steering Committee is conducting 11 surveys through Indian country to identify women's health issues and will be making recommendations to the Director of IHS.

Substance Abuse and Mental Health Services Administration

- The IHS along with other Federal Agencies are working with SAMHSA to support several Native American collaborations addressing mental health and the "Indian Self Determination: Summit on Tribal Strategies to Reduce alcohol, Substance Abuse and Violence."

COLLABORATION WITH OTHER FEDERAL AGENCIES

Department of Interior/Bureau of Indian Affairs

- The IHS along with other Federal Agencies are working with the DOI/BIA to support several Native American collaborations addressing mental health, domestic violence abuse and

neglect, and the "Indian Self Determination: Summit on Tribal Strategies to Reduce alcohol, Substance Abuse and Violence."

- The IHS continues to work with the BIA to provide technical assistance and training for background checks of employees of tribal health programs.

- The IHS continues to be a partner in the support of the IHS/BIA Annual Youth Conference reaching junior high and high school and college teens with an agenda that covers a wide variety of life issues.

Department of Justice

- The IHS and other Federal agencies have partnered with the U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention and Office of Community Oriented Policing Services to support coordinated activities in mental health and community safety for AI/AN children, youth, and families. The grant funds are for a 3-year period to provide tribes with easy-to access assistance in developing innovative strategies that focus on the mental health, behavioral, substance abuse, and community safety needs of AI/AN young people and their families

- The IHS and other Federal agencies have partnered with the U.S. Department of Justice, Offices of: Tribal Justice, OJP Corrections Program and Office of Justice Program to co-sponsor the "Indian Self Determination: Summit on Tribal Strategies to Reduce alcohol, Substance Abuse and Violence." The conference will focus on developing a national agenda on alcohol, substance abuse and violence for Indian country; and an opportunity for Federal agencies to highlight promising practices and strategies on alcohol, substance abuse and violence. Tribes will be given materials, and they will be able to network with researchers.

Environmental Protection Agency

- The IHS and EPA have several interagency agreements to coordinate activities of both agencies pertaining to the environment and human health of AI/AN and their lands. Through their joint effort the EPA can provide resources to the Sanitation Facilities Construction Program's national network of staff to promote their mutual interests, create cost-efficiencies and eliminate overlapping responsibilities, i.e., design and construct wastewater treatment projects.

- In their partnership with EPA, the IHS also enters into Memorandums of Understanding (MOU) with tribes to apply and manage Clean (CW) Indian Set-Aside grants to develop and manage their water and sanitation facilities program. The IHS and EPA provide technical guidance and support throughout the process.

Federal Emergency Management Agency

- The IHS, the Federal Emergency Management Agency (FEMA) and the U. S. Fire Administration (USFA) are collaborating to reduce the rate of fire and burn injuries in American Indian and Alaska native children, ages 0-5 years to half the national average by the year 2010. Fire is the leading cause of childhood injury death in the home and children under five years of age are at the highest risk.

U.S. Army Medical Command

- The IHS and the U.S. Army Medical Command collaboration permitted the IHS to access the Army's contract with Med-National. Med-National is a health manpower recruiting firm located in San Antonio, Texas. Through Med-National, the IHS has access to an alternate source of dental manpower and has been able to place 6 dentists in IHS and tribal dental clinics.

United States Department of Agriculture

- The IHS continues to work with the USDA for WIC services for Head Start Indian children to provide basic nutrition food items to ensure health physical development of children between ages 1-5 years old.

Uniformed Services University of the Health Sciences

- The IHS also has a collaborative agreement with the Uniformed Services University of the Health Sciences (USUHS) for technical assistance in ensuring environmental compliance of IHS health care facilities. During the past year, USUHS staff developed a comprehensive hazardous materials and waste management plan that will be applied in all IHS facilities.

Department of Veterans Affairs

- Nationally, the IHS is collaborating with the VA on targeted data systems and credentialing to increase the number of Native American veterans eligible for services and to identify under-served areas of Indian country where Native Americans reside.

- The IHS, HFCA and the Social Security Administration plan to include the VA in their collaboration to develop an agreement targeting education and outreach of veteran beneficiaries who are underutilizing their benefits and services.

- Many local IHS facilities have care agreements and pharmaceutical supply agreements with nearby VA facilities that maximize capabilities and extends the outreach of services for both agencies.

- The IHS participates in the VA Pharmaceutical Prime Vendor Program. By collaborating with the VA and being included on the VA Pharmaceutical Prime Vendor program and on VA National Acquisition Contracts, the IHS is able to take advantage of national drug contract prices negotiated by the VA. This allows the IHS to purchase selected pharmaceutical at substantially discounted prices, even lower than Federal Supply Service (FSS) prices in most cases. The IHS has been participating for several years and plans to continue this collaboration indefinitely. The program has resulted in very substantial savings for IHS over the years.

OTHER PROGRAM COORDINATION BY SUBJECT

Obstetrics and Gynecology Training and Technical Assistance from the American College of Obstetrics and Gynecology (ACOG)

- The American College of Obstetricis and Gynecologists (ACOG) Fellows In Service Program recruits and screens Board Certified or Active Candidates for Board Certification obstetrician-gynecologists (OBG's) for short term assignments in IHS facilities. These fellows augment local IHS staff when their OBG's are away for leave, educational training, maternity leave, or prolonged illness or disability. There are approximately 8-12 assignments each year, with 11 having been assigned this past year. A number of requests have already been made for this year's program.

- The ACOG Committee on American Indian Affairs meets with IHS Headquarters, Area, and Service Unit staff 2-3 times a year and conducts an Area-wide obstetric and gynecologic quality of care consultation site visit annually. All Areas with full-service obstetrics and gynecology programs are site visited on a rotating schedule.

- The ACOG-IHS Postgraduate Course on Obstetric, Neonatal, and Gynecologic Care is presented annually by specially recruited and selected ACOG and IHS faculty for approximately 100-110 IHS and tribal physicians, advanced practice nurses, and clinical nurses. This course is designed to provide a week-long update of obstetric, neonatal, and gynecologic care with the focus on practices appropriate in the primary care setting in often smaller or more remote facilities.

Injury Prevention

The mission of the IHS Injury Prevention Program is to decrease the incidence of severe injuries and death to the lowest possible level and increase the ability of tribes to address their injury problems. The IHS has initiated an aggressive public health attack to prevent traumatic injury among American Indians and Alaska Natives. Primary emphasis is directed to the injuries of the greatest cause, such as motor vehicle crashes, and to the most common risk factors, such as lack of occupant restraints, alcohol impaired driving, and poor road conditions in rural areas. Other emphasis areas are in childhood injury, the prevention of house fire-related injuries, and building

the capacity of Tribes to address injuries in local communities through core programmatic funding and training in injury prevention.

To accomplish their mission, the IHS Injury Prevention Program has formed partnerships with many government and non-government agencies. The IHS has a collaborative agreement with the National Center for Injury Prevention and Control of the CDC for the purpose of injury prevention, with specific areas of interest in injury epidemiology and surveillance and in the evaluation of community-based injury prevention and control activities. During the past year the CDC and the IHS collaborated with the American Academy of Pediatrics and several tribal groups to present the first ever briefing on injury issues to staff from the Senate Select Subcommittee on Indian Affairs.

Other formal Interagency Agreements exist between IHS and the U.S. Fire Administration, and the National Highway Traffic Safety Administration. Program staff work with many other agencies and groups including the following; the National Safe Kids Campaign, the Consumer Product Safety Commission; Bureau of Indian Affairs' Law Enforcement Services and Division of Highway Safety; American Academy of Pediatrics, Committee on Native American Child Health and the Committee on Injury and Poison Prevention; Federal Highway Administration; HRSA's Maternal & Child Health Bureau; The Johns Hopkins University; Harborview Injury Prevention Research Center; and private foundations.

1.4 Summary FY 2001 Performance Report: Accountability Through Performance Measurement

A History of Commitment to Performance

The IHS has practiced performance management and performance measurement for almost a half of a century. We have demonstrated this commitment by being pioneers in quality assurance in health care, health services resource planning, the application of information technology to health care, the use of alternative providers, and the application of the Community Oriented Primary Care approaches to health care delivery. These efforts and many others were essential to achieving the mostly unspoken and unwritten commitment adopted by most I/T/U staff to accomplish the most good (i.e., improved health), for the largest number of people, at the lowest possible cost, and in a manner that is acceptable to the consumer and the provider. As presented in Section 1.2, between 1972 and 1994, these efforts resulted in dramatic improvements in mortality rates for AI/AN population. When the resources used to accomplish these improvements are considered, it is not an overstatement to contend that the IHS has set a benchmark in public health efficiency in this country.

During our early years the results of our efforts were published as reports and journal articles from across the healthcare disciplines, often in collaboration with outside researchers and evaluators. While this collaborative approach is still used today, since 1984 the results of these efforts in terms of the health services provided, health outcomes, and other relevant demographics of AI/AN people have been annually reported in the publication ***Trends in Indian Health***. In 1990, a second annual report, ***Regional Differences in Indian Health,*** was added to provide similar information specific to each of the 12 IHS Areas. While performance management and performance measurement have come a long way with the implementation of GPRA, it represents a new challenge but a familiar concept for the IHS.

Performance Summary

The improvements in access to critical primary services documented with the performance reports for FY 1999 through FY 2001 represent important steps in reducing the mortality and morbidity of chronic diseases. Likewise our indicators addressing prevention activities and pilot projects offer the potential to ultimately reduce the prevalence of these same chronic diseases. However, making significant strides in reducing the health disparities in the AI/AN population will require continued improvements in access to treatment and preventive services to be sustained for many years as well as addressing the related problems of unemployment and poverty. These issues are discussed in the next section of this document.

Several of the FY 2001 targets were significantly surpassed. Indicator 30 committed to establishing five tobacco control centers as part of a collaboration with the CDC, but we succeeded in establishing seven. Indicator 33 committed to applying an environmental surveillance protocol in 15% of AI/AN communities. However, with the adoption of the IHS's recently developed Web-based Environmental Health Reporting System (WebEHRS) we were able to extend this capacity and support in 100% of the IHS Environmental Health programs and there are currently 175 WebEHRS users and 19,052 community-based environmental health facilities and services tracked through the system. WebEHRS provides these programs a

valuable cost-effective tool to assess their environmental health workload, and plan and monitor their program activities to meet the public health problems. During FY 2002 it is being expanded to tribal sites.

Another example of exceptional performance is Indicator 35 that committed to providing sanitation facilities to a total of 14,730 AI/AN homes. This target was surpassed by 22% in completing 18,002 homes through partnership with other organizations that resulted in additional resources to direct at this important public health service.

From another perspective some of the indicators that we have counted as "not met" could be described as "near misses" or components of longer-term successes. Indicator 10 committed to increasing by 10% the proportion of I/T/U prenatal clinics using case management protocol for pregnant substance abusing women. While the target was not met with a 7.1% increase, the combined FY 2000 and FY 2001 target increase of 15% was surpassed with a total of a 16.3% over both years leaving just under 95% of I/T/Us now using these protocols.

Not achieving the childhood immunization indicator for the third year was probably the biggest disappointment of FY 2001. While our coverage rates still are above national averages, particularly for underserved populations, it is a service of highest public health importance and we remain committed to improving on this indicator. As is the case with other clinical measures, the problem of recruitment and retention of clinical providers and the growing demand for urgent care remain the largest underlying contributors to not achieving the performance target.

Several of larger indicator groups are worth discussion individually and are now presented.

Diabetes Group

The IHS has been cited as a model of community involvement and program effectiveness for the use of the IHS *Diabetes Care and Outcome Audit* to measure diabetes care in AI/AN communities. The Diabetes Care Audit assesses a range diabetes care and education for approximately 80,000 IHS diabetes patients. These measures have been incorporated into the National Council on Quality Assurance/American Diabetes Association proposal for national performance benchmarks for diabetes care.

IHS chose four of the Diabetes Audit measures as GPRA goals because of their proven benefits in reducing morbidity and mortality from diabetes: increasing the percent of persons diagnosed with diabetes with improved control of blood sugar, blood pressure, and cholesterol and the percent assessed for kidney health. Of particular importance in terms of long-term improvements in diabetic morbidity, trends from 1994-2000 audit data indicate a continued improvement in blood sugar and cholesterol levels and assessments of kidney health. Blood pressure control has been relatively unchanged.

The improvement in control of LDL cholesterol is likely due to several factors: a better awareness in both providers and patients through the National Cholesterol Education Program efforts; increased provider awareness of the growing problem of cardiovascular disease (CVD) in AI/AN through efforts to publicize results of the Strong Heart Study, which shows the rate of

CVD in AI/AN is increasing while it is decreasing in the general population; and better availability of statin drugs in our pharmacies which are very effective in treating dyslipidemias.

Annual changes in blood pressure control have not been statistically significant and can be attributed to the sample population changing each year. Furthermore, the alarming increase in overweight and obesity in youth and adults and the rising incidence of cardiovascular disease among AI/AN patients with diabetes may have a significant impact on the outcomes of this measure. The IHS National Diabetes Program is encouraging programs to use the new diabetes funding to enhance their clinical care programs, including better blood pressure screening and more aggressive treatment, assessment of cardiovascular risk, as well as increased funds to the pharmacy budget to purchase newer, more effective antihypertensive agents.

Offering hope that a rapid rise in diabetes can be reversed, the preliminary findings from the Diabetes Prevention Program (DPP), a major NIH clinical trial comparing diet and exercise treatment to treatment with Metformin in adults with impaired glucose tolerance, found that even modest lifestyle changes – eating less fat, exercising 30 minutes a day, and losing a moderate amount of weight – cut the incidence of diabetes by more than half among those most at risk. Participants randomly assigned to intensive lifestyle intervention reduced their risk of developing type 2 diabetes by 58 percent. On average, this group maintained their physical activity at 30 minutes per day, usually with walking, and lost 5-7 percent of their body weight (an average of 15 pounds), using a low fat diet with moderate calories (1200-1800/day). It is particularly significant that four Indian communities were included in this investigation and their results paralleled those from other study sites.

This research provides important new tools that the IHS and the tribes can use to address the rise of new cases of type 2 diabetes. Indicator 29, which has been focused on childhood obesity since the initial IHS performance plan in FY 1999, has been redirected for FY 2002 and beyond to the DPP and other emerging technologies to address diabetes, obesity, and cardiovascular disease more globally across the Indian health care system.

Oral Health Group

Taken as an integrated set, indicators #11, 12, and 13 provide a measure of three aspects of the dental program that collectively have the potential to significantly impact oral health outcomes. Access to care (Indicator #12) is strongly associated with oral health. Periodic examinations allow for the detection of incipient disease: these visits give the oral health care provider the opportunity to provide meaningful oral health education and preventive services. Timely restorative care results in quick control of incipient lesions. Periodic access to dental care is associated with individuals generally better informed about their own oral health. Addressing overall access to dental care remains the dental programs greatest challenge and while the target of 27% was not achieved it was increased from 25.1% in FY 2000 to 26.3% in FY 2001 in the face of a growing population and continued high vacancy rates for dentists. It is worth noting that the national average for annual access to dental care has stood at just over 60% for several years. In the early 1990s at the IHS dental program's peak in terms of per capita resources, we achieved a rate of approximately 34% annual dental care access for the AI/AN people. Thus, addressing this access disparity today remains formidable but a continued priority for the IHS.

The benefits of water fluoridation and dental sealants (Indicators #11 and #13) are well documented. Both are proven to prevent dental decay, the most common oral disease. Both are painless, and associated with significant decreases in disease both in individual cases and on an epidemiological or public health, population based level. Taken together, these indicators provide a valid estimate of the effectiveness of a dental public health program. Significant and well-documented progress toward the goals of providing increased access to care, fluoridation, and dental sealants implies a significant, long-term positive impact on the oral health of those individuals served. The meaningful gains made with respect to all three indicators define both progress and the challenge remaining.

The fluoridation gains documented at the demonstration sites that met the performance target represent additional large numbers of individuals benefiting from this key dental public health preventive measure. Utilizing the lessons learned at these demonstration sites, these successes must be replicated in a timely manner throughout Indian Country and particularly in the non-demonstration Areas that did not improve in FY 2001.

The gain in prevalence of sealants made in FY 2001, though short of the targets, represents thousands of teeth in a population of children and adolescents at high risk for decay that are now highly protected from the disease process. Sealants are particularly important to the preventive efforts of the dental program, as they are generally targeted toward ages particularly susceptible to the disease of dental decay. It is also worth noting that the IHS dental program was one of the few dental programs in the nation to have achieved the Healthy People 1990 and 2000 dental sealant objectives.

Taken together, the three dental indicators hold the key to a significant, long-term improvement in oral health. The fact that the dental program documents significant gain in the indicators associated with each of these preventive measures in highly consequential, as it holds the promise of positive health outcomes if the progress can be sustained.

Developmental Prevention and Treatment Group
Indicators 28-30 are collaborative pilot projects with tribes and outside organizations to address cardiovascular disease, obesity, and tobacco control respectively. All targets were achieved and two were surpassed. As successful applications from these projects become evident, they will be diffused across Indian Country. For FY 2002 and beyond, the indicators addressing obesity and tobacco control have now evolved from pilot project more global IHS-wide efforts to address these public health problems. Given that obesity and tobacco represent two of the most significant preventable causes of death, they are critical to addressing the escalating death rates of AI/AN people. Their success will be highly dependent on the strength of the collaborations that underpin them and provide expertise, essential infrastructure, and the capacity to diffuse effective technologies to the larger AI/AN population.

Consultation, Partnerships, Core Functions, and Advocacy Indicators
Of the five indicators under this category in FY 2001, three were accomplished, one was not met, and one will not be reported until later this fiscal year. The achieved indicators addressed improving tribal consultation (Indicator 37), developing cost accounting capacity (Indicator 40), and developing protocols to support the efficient, effective and equitable transfer of management of health programs to tribes submitting proposals or letters of intent to contract or compact IHS

programs under the Indian Self-Determination Act (Indicator 42). These all represent critical internal management functions that significantly contribute to our Mission.

The single unachieved indicator for FY 2001 addressed raising our Human Resource Management (HRM) Index employee survey score by one point to 97. This goal was not met with a FY 2001 score remaining at 96 as it was in FY 2000. This lack of progress is attributed to continued high vacancy rates for health care providers in many clinical settings putting considerable strain on current IHS staff. This problem represents one of our most demanding challenges and is the underlying contributor to virtually all of the clinical care performance targets not achieved since FY 1999 and is discussed in greater length in the next section of this report.

Information Technology Development and GPRA

While we had hoped to report on a larger number of indicators with this submission, major efforts in addressing data quality and the "user population" as described later in this discussion have delayed these analyses. In terms of long-term data quality, we contend these delays are clearly justified.

Reporting on GPRA indicators is dependent upon a reliable data system. The IHS's data system supports and facilitates the integration of clinical, administrative, and financial data in healthcare facilities. The Patient Care Component of the RPMS is an automated system for the collection, storage, and output of data gathered and recorded on a variety of forms or directly into the system at the point of patient contact in the outpatient, inpatient, and field visit settings. It has been implemented with a basic level of uniformity at more than half of the 500 plus IHS, tribal, and urban facilities. Many challenges confront our support of a data system that serves disparate clinical environments. These include the number of facilities that we serve and the lack of national standards for data recoding and transmission.

The IHS has supported ongoing improvements and enhancements to the RPMS system, including the development and deployment of a GUI (graphical user interface). Application development and enhancement are designed to improve the clinical as well as administrative usability of this system and are proposed, designed, implemented and evaluated based upon a quality improvement process.

The IHS has also developed a new software application (GPRA+) that is designed to passively extract GPRA clinical indicator information from the RPMS system. This new application, which will be deployed in FY 2002, should allow for local, as well as regional, compilation of clinical GPRA indicators. The application will allow providers to track their own performance based upon the GPRA clinical indicators (similar to the use of HEDIS by individual providers).

Ultimately, the IHS is working on a uniform process for the development and implementation of all indicators and data need, regardless of reporting requirement (GPRA/performance management, accreditation, ongoing program monitoring). This will facilitate a consistent design and implementation process.

FY 2001 Diabetes Indicators 1-5 rely on a manual audit of diabetes charts. However, as shown in indicator 16, this manual audit will soon be replaced with electronic queries of our clinical database. This indicator expands the automated extraction of the GPRA clinical performance measures directly from automated clinical information systems. This improvement in data quality will facilitate the eventual reporting of all clinical indicators via an electronic search tool. Data for indicators 1, 6-8, 24, and 26 are currently being obtained using these electronic queries for FY 2000 and FY 2001 data and will be reported by this April.

Automating extraction of data in this way will allow IHS to add new performance measures in the most cost-effective way, without imposing additional data collection burdens on health care staff. It will also support other IHS management efforts – delivering high quality clinical care, managing programs, quality improvement, monitoring epidemiological trends, performing clinical research, etc. This effort is on the cutting edge of medical informatics. To our knowledge, no other healthcare organization, public or private, has developed a large enterprise-wide system that has the capacity to report on a wide range of clinical measures from existing clinical information systems. The IHS continues to believe that national data compilation should be transparent to end users such as agency leadership and Congress and at the same time provide user friendly tools to facilitate tracking and improving direct patient care at the local sites.

The implementation of a Data Quality Action Team (DQAT) reflects the IHS's commitment to improved IHS specific data. This team is currently in the process of developing and implementing a data warehouse pilot project. This data warehouse will enable the IHS to aggregate national data that is free of duplication; this will allow us to have dramatically improved data quality. Once the warehouse exists, the IHS will be able to develop 'data marts' that are aggregated subsets of the master database. Through the use of query tools IHS will be able to extract accurate data from our data warehouse in a reproducible manner.

The data warehouse is designed to eliminate duplicate users, and to ensure accurate user population information. This may result in significant changes in the data reported under GPRA that is dependent upon user population information. New accurate denominators and numerators will need to be established for the clinical indicators that are dependent upon user population information. In addition, appropriate recording of data by service providers and the entry of those data by data entry staff is essential to improving data quality IHS has already begun to implement a pilot web-based training for local facility staff to improve both the recording and entry of data. This intervention includes an evaluation component that will allow us to assess its effectiveness.

Status of Final Reporting of Performance Indicators

With this submission the IHS has reported on 26 of the 27 performance indicators for FY 1999. The single remaining unreported indicator for FY 1999 addresses injury mortality and comes from data provided by the National Center for Health Statistics, which we have now received and which is currently being analyzed. Final performance information for this indicator will be available by February, 2002. For FY 2000, several indicators that were reported with provisional data (#s 1, 6-8, 13, and 22) are being concurrently analyzed again along with the FY 2001 data now that both computer-based data sets have been verified. These analyses will be complete by April 2002 at which time all but one of 34 indicators for FY 2000 will be reported. For FY 2001,

we are now reporting on 26 of the 38 active indicators, but we are not presenting findings based on provisional data.

Key External Factors Influencing Success

A variety of external factors have functioned as powerful determinants in the level of attainment of the FY 2001 Performance Report and will continue to influence our success in future performance reports. It is important to acknowledge that for many of these factors the distinction between what is external versus internal is often blurred. However, making this distinction is a critical element in successfully addressing them.

Recruitment and Retention of Health Care Providers

As acknowledged in the previous section, vacancy rates for some health care providers are at the highest level in IHS' history and are directly related to difficulties in both the recruitment and retention of these providers. The reasons for these recruitment and retention difficulties are complex and include both external factors as well as factors within the I/T/U settings. The broader external factors are the growing debt levels for health professionals leaving school, coupled with increasing earning potential in the private sector as a result of a healthy economy and relative shortages of these health professionals. The factors within the IHS context include relatively poor salary parity between the Federal systems and the private sector, isolation and a lack of urban amenities in many reservation settings. Furthermore, limited spousal employment opportunities, ancillary support, and clinical space to address an ever-increasing patient load, have also contributed to recruitment and retention difficulties.

These local factors have been compounded by diminished professional support to IHS managed programs because of downsized Areas and Headquarters that has occurred in response the continued transition to tribal management of health programs. While this Area and Headquarters downsizing was a planned part of the self-determination process, it resulted in a loss of economies of scale greater than expected.

Collectively these trends and associated reductions in career development and training opportunities appear to have resulted in a decrease in morale of IHS providers. Objective indicators for this trend include the relatively low score of the IHS in the 1998 and 1999 HHS surveys that define the Human Resource Management Index from the Department as a whole and for each OPDIV. This annual process is based on a survey of a sample of employees from each HHS agency and has been designed to assess several recognized components of the "quality of work life." While we are pleased to report that the IHS score for this survey did improve for FY 2000, it was unchanged for FY 2001 and still remains below the Department average. Clearly a sustained effort will be needed to meet the performance targets for FY 2002 and FY 2003.

Lastly, there has been a significant increase in EEO filed complaints during the past few years within the IHS. While this trend is undoubtedly the result of many factors, it is likely that staff morale and the stresses of downsizing have been contributing factors. Thus, the net effect of these trends is to compound the retention problem because the staff are affected by diminished support and overwhelmed by the patient load. For consumers, the waiting times for appointments increase and complaint rates increase. This can result in staff becoming

discouraged and resigning as well as patients giving up trying to access the system for health care needs except emergencies. In effect, patients may not proactively seek services such as well-baby, cancer screening, dental care, or diabetes control.

The IHS is committed to improving its performance in the recruitment and retention of well-qualified health care providers and the FY 2000-2003 Budget Requests and Performance Plans strategically address this problem. Activities directed towards this end include:

- expanding web-based recruiting efforts
- expanding consideration of alternative Federal pay structures to address pay parity issues
- expanding the loan repayment program and making it more flexible for I/T/U use
- developing alternative mechanisms to support health disciplines in partnership with tribes and tribal organizations including the addition of two Tribal Epidemiology Centers and four Dental Clinical and Preventive Support Centers
- continuing efforts to enhance quality of work life (QWL) through greater adoption of HHS QWL policies and enhanced leadership training

The Role of Poverty

The relationship between poverty and higher levels of morbidity and mortality for both acute and chronic diseases and conditions has been documented worldwide. In fact, many of the racial and ethnic disparities in health status disappear when analyses control for education and socioeconomic status. Across Indian Country, mortality and morbidity rates generally follow the general economic indicators such a socioeconomic status, employment rate, and also educational level. As noted in the introduction of this document, the IHS serves several of the poorest communities in the country that also have the lowest life expectancy rates.

While increasing access to comprehensive health services over time will reduce both mortality and morbidity to some degree in these situations, health services alone are not likely to eliminate the huge health disparity gap that now exists, unless the other complex factors contributing to poverty are also addressed. However, it must be acknowledged that the current challenges associated with access to many essential services are contributing not only to poor health but also to poor economic conditions. Indeed, poor health status should be viewed as both a cause and an effect of poverty.

We offer an example of how powerful even relatively mundane and non life-threatening health problems can be when they reach extreme levels. Between 1988 and 1991 the IHS Dental Program participated in the World Health Organization sponsored International Collaborative Study of Oral Health Outcomes. Data were collected on the Lakota Sioux Indian people on the Pine Ridge and Rosebud Reservations in South Dakota and on Navajo people in the northeast corner of the Navajo reservation in Arizona and New Mexico. Other study sites include Baltimore and San Antonio in the United States and Latvia, France, New Zealand, and Japan. The study included calibrated and standardized oral examinations with assessments of disease rates and treatment needs and a detailed patient interview that included a history of dental experiences and problems.

The oral health examination corroborated findings from IHS surveys that the oral conditions of Navajo and Lakota Indian people were very poor with disease rates two to four times that of all other study sites. Findings from the studies patient interview that assessed the impact of oral health on a variety of quality of life measures revealed the following alarming findings:

- one third of school children report missing school because of dental pain.
- 25% of school children avoid laughing or smiling and 20% avoid meeting other people because of the way their teeth look.
- as a consequence of dental pain, almost a quarter of the adults are unable to chew hard foods, almost 20% report difficulty sleeping, and 15% limit their activities (i.e., work and leisure).
- three quarters of the elderly experience dental symptoms, and half perceive their dental health is poor, or very poor and are unable to chew hard food.
- almost half of the adults avoid laughing, smiling, and conversations with others because of the way their teeth look.

These "quality of life measures" were 200 to 400 % more severe for the Indian study respondents than those from any other sites including Baltimore and San Antonio. Clearly, conditions of this magnitude represent significant disparities in health status and are not just dental problems, but have significant social, psychological, and economic consequences on peoples' self-esteem and their ability to learn, secure employment, and reach their full potential. When such dental conditions are superimposed on top of other prevalent conditions normally considered far more severe such as diabetes, alcoholism, and family violence, a person's capability to achieve self-sufficiency is seriously compromised.

There is little doubt that in many AI/AN communities health status is contributing to the economic hardship they experience. It is also true that improved health care alone cannot make up for the lack of opportunities for economic development. Some tribes are making significant progress in this process and many of these are the ones who have exercised their option under the Indian Self-Determination legislation to manage their own health programs. While the IHS is not an economic development organization, we are committed to assuring that our available resources are used effectively to minimize the negative effects of poor health status on the general socioeconomic well being of AI/AN communities. Furthermore we are working to collaborate with the BIA, the Administration for Native Americans, and with other organizations with the capacity to assist in economic development. Our success in improving the health status of the AI/AN population in this century will continue to be strongly influenced by the overall success of efforts to address poverty in Indian Country.

A Lack of Cost-Effective Interventions for Chronic Diseases

A major challenge the IHS must address is how to provide health care in the face of increasing mortality and morbidity rates for diseases such as alcoholism, diabetes, and cancer that represent extremely costly conditions to treat. Of these problems, perhaps diabetes represents the greatest economic challenge to the IHS. Tribal communities within the I/T/U system have the highest diabetes prevalence in the world with many other communities showing accelerating increases annually. While the NIH supported Diabetes Prevention Program demonstrated encouraging success in reducing the incidence of diabetes by more than half among those most at risk, the cost of effectively implementing this across the many AI/AN communities with great need represents a serious barrier.

Until a preventive technology is developed, we are faced with the costly medical management of treating patients with diabetes that is currently estimated in the diabetes literature at $5000 to $9000 per patient per year. The IHS is funded at approximately $1400 per person per year with Medicare/Medicaid, private insurance collections and out of pocket expenditures adding an estimated $500-700 more. Thus, AI/AN people are funded at approximately $2000 per person annually compared to almost $4000 for the U.S. general population. In communities where the diabetes prevalence is approaching 40-50 percent, the entire available per capita funding could be completely consumed in treating diabetes, leaving no resources for clinical management of alcoholism, cancer, injuries, oral health, prenatal care, and well-baby/immunizations to name only a few.

Given these economic realities, the I/T/Us are faced with difficult choices in assuring access to essential health care. While there are always ways to improve efficiency and effectiveness and "do more with less," at least in this country, there are no private or public health systems that have set more cost-effective benchmarks for effectively addressing diseases problems of this magnitude then the IHS. It appears decidedly easier to show a profit in the health care industry than to improve the health of the poorer segments of the population. We contend that since our inception in 1955 to the early 1990s, the IHS has set the benchmarks for rural health care efficiency and effectiveness.

Clearly our long-term success in improving the health of the AI/AN population will be strongly influenced by the development of major cost-effective treatment and/or preventive technologies for addressing the many health conditions AI/AN people experience at high rates.

Third Party Collections

The IHS has established a priority to identify any available alternate resources and fully maximize third party collections for delivery of health care services. This priority was established in recognition that increasing collections is a critical element to maintaining and improving the delivery of health services to the IHS service population. Over the last few years the IHS has significantly increased its third party collections, as a result of higher negotiated Medicare and Medicaid rates, new authority to bill under CHIP and more efficient business management practices, involving patient eligibility determination, documentation of services and processing of claims. These increases have been critical to the I/T/U's ability to meet increasingly demanding accreditation and quality standards and maintain access to services in the face of growing health demands driven by population growth and increasing health disparities.

Specific to GPRA, third-party collections clearly contribute to many performance measures and are considered in a general way in setting performance targets. However, it is difficult to link collections to specific GPRA indicators in a quantified way for several reasons. First, unlike our budget authority that is specifically identified each year, we can only estimate our collections. We are able to do this with some accuracy because we do have previous year's collection amounts for all but a few freestanding tribally operated facilities. Our data on how these funds are actually used is considerably less specific. We do not have data on how collections are used by tribal programs because they are not required to provide it. Secondly, within direct care settings our accounting system only identifies how collection are used at the object class level

and this data is included IHS budget justifications each year (see page 147 of the FY 2003 budget justification). As a result, with our existing accounting capabilities there is no practical way to show for which funding categories or indicators these collections are being used in the many diverse IHS settings. Therefore capturing of such information with our current systems would be impractical and not cost-effective in the context of GPRA or sound public health practices.

The strongest link between these collections and a specific performance measure is Indicator 21 that addresses maintaining the accreditation of health care facilities. First priority for use of collections is directed to funding activities necessary to maintain JCAHO accreditation standards, including specific compliance with deficiencies documented during JCAHO/CMS surveys. As a result, specific use of collections to meet accreditation standards varies widely across our health care facilities. In some cases these funds are used to support health care staff positions and others to support building maintenance and compliance with life safety codes. In terms of the four broad budget aggregation categories on which our performance plan and indicators are based (see page 44), a crude estimate for how these funds are directed would be 85 percent into the "Treatment" aggregation and 15 percent into the "Capital Programming/Infrastructure" aggregation. We have included estimated collections levels in the summary tables for these two aggregation categories (see pages 55 and 127).

We are encouraged that IHS and CMS have been working in collaboration under a Joint IHS/CMS Steering Committee to address major policy issues that improve the delivery of services to IHS populations who have Medicare and Medicaid eligibility. Many of the issues that have been addressed and that are being addressed by the Joint Steering Committee have some impact on IHS' ability to achieve the above objective of optimizing maximizing third party collections. For example, joint efforts to develop cost reports contribute to ensuring that IHS receives a fair reimbursement for its services.

Most recently, the IHS/CMS Steering Committee have focused on developing a plan to implement the recently enacted legislation that authorizes the IHS under Part B to bill and collect for physician services provided to Medicare beneficiaries. Indeed, maximizing third-party collection will remain a critical activity in the achievement of the IHS Mission.

Transitions to Tribal Management

The rate of transition to tribal management of health programs has and will continue to represent a significant challenge to the IHS. This transition toward tribal management of health programs has required Area Offices and Headquarters to downsize significantly. While this was a planned part of the Self-Determination process, an unfortunate side effect of this downsizing has been the loss economies of scale and reductions in the IHS public health infrastructure. From a more positive perspective, we are encouraged by the trend of increasing tribal management of critical public health components of the Indian health system including Tribal Epidemiology Centers and Dental Clinical and Preventive Support Centers.

There is also evidence that the transfer of resources and management control to tribes has freed them to innovate, develop alternative resources, find new mechanisms for building facilities, and enhance patient care, which ultimately will improve outcomes. What is still not completely clear

at this time is at what level tribal programs will participate in GPRA performance measurement, given that it is voluntary based on current regulations. While a growing number of tribal programs have expressed a commitment to submit data for GPRA in response to our active marketing of its importance, some have expressed resistance based on a belief that it represents an optional administrative activity that diverts resources away from patient care.
Indeed the IHS is in a challenging position with the responsibility of including tribal programs in performance reporting, but lacking the authority to require tribes to submit their data. Despite these challenges the IHS remains committed to tribal self-determination and to performance management and views both as essential to the realization of our Mission and Goal.

The implementation of GPRA in the IHS has resulted in some continued benefits that are likely to contribute to future success. First, the GPRA/Budget Formulation process has increased collaboration and understanding of public health and budgeting across the diverse IHS stakeholders. The process of addressing these issues beginning at the local level and moving up has aligned and mobilized tribal leaders and consumers about funding issues that address significant public health problems. In this process health program staff have learned more about the IHS budget process and budget/finance staff have learned more about public health. But probably of most importance, tribal leaders and consumers have had the opportunity to have dialogue about the "big picture" of Indian health and learn more about both public health, budgeting and the importance of accountability at all levels of the Indian health care system.